Virginia Department of Game and Inland Fisheries
Complementary Work Force Program

APPLICANT REFERENCE INFORMATION FORM

Please Type or Print.

Applicant:_____
First Name Middle Name Last Name (Nickname)

Address: _____

City: _____State: _____ZIP: _____

PLEASE PROVIDE THREE CHARACTER REFERENCES:

NAME: _____
ADDRESS: _____
CITY: _____STATE: _____ ZIP: _____
PHONE NUMBER: (_____)_____

NAME: _____
ADDRESS: _____
CITY: _____STATE: _____ZIP: _____
PHONE NUMBER: (_____)_____

NAME: _____
ADDRESS: _____
CITY: _____STATE: _____ZIP:_____
PHONE NUMBER: (_____)_____

The undersigned agrees to permit the Virginia Department of Game and Inland Fisheries to contact references in determining eligibility for participation in the Complementary Work Force Program.

Applicant Signature Date

DGIF USE ONLY

REFERENCES CHECKED BY COMPLEMENTARY WORK FORCE REGION COORDINATOR:
REGION: _____

NAME: _____ DATE: _____

SIGNATURE: _____
Does Applicant Meet Program Screening Criteria?_____ (yes/no)
Notes attached _____ (yes/no)

SIGNATURE OF STATE COORDINATOR:

_____

Date: _____

Rev.8-6-07